STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-Compliance Revisit.	{F 000}		
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility had a census of 46 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior on 2 of 2 halls where residents resided for 2 of 2 days of the survey. Findings included: - On 6/4/13 and 6/5/13 various observation revealed the carpet by the nurse's station stained, some areas lighter than others, and the carpet in the television area stained. On 6/4/13 at approximately 8:35 A.M. observation revealed the floor tile with heavy black stains/marks at the foot of the resident's bed on the south hall, a dirty stool riser and the bottom of the toilet bowl with a black colored substance in a resident's bathroom on the north hall. Observation of the common bathroom on the north hall revealed a wall with several missing tiles, rust by the right side of the toilet, no cover on the toilet bolt, a white color substance located on the side and front of the shower, and a brown colored substance by the shower. The above observations were again observed on 6/5/13 with the exception of the missing tiles in the north	{F 253}		4/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 253}	Continued From page 1 common bathroom and the dirty stool riser. On 6/4/13 at 9:32 A.M. and on 6/5/13 at 10:15 A.M. observation revealed tile chipped at the entrance to the bathroom located on the south hall, the bottom of the toilet bowl with chipped enamel, heavy laden white colored substance behind the toilet, and at the entrance to the shower, and the shower stall with 3 stained areas. On 6/4/13 at 3:50 P.M. a red colored substance was located next to a pipe behind a toilet in a resident' bathroom on the north hall, and heavy laden of dust by the baseboard in front of the toilet. On 6/5/13 at 7:15 A.M. housekeeping staff X stated the red colored substance was a fire retardant, and confirmed the heavy laden of dust by the baseboard. During tour with administrative staff A on 6/5/13 at approximately 10:25 A.M., staff confirmed the heavy white substance, and the chipped tile at the entrance of the common bathroom on the north and south hall, the chipped enamel in the toilet bowl (south common bathroom), heavy black marks on the floor tile in a resident's room on the south hall, the stained carpet by the nurse's station, and in the television area of the facility. During tour with maintenance staff Y on 6/5/13 at approximately 10:50 A.M. staff stated the white substance in the north and south bathrooms was concrete, and the white color would fade over time. Maintenance staff Y stated there were holes by the baseboards and he/she filled the holes with concrete. Maintenance staff Y stated the facility had removed a pipe located next to the toilet in the north bathroom, which resulted in the	{F 253}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 253}	Continued From page 2 rust spot, and confirmed the north bathroom toilet bolt without a cover. During interview with housekeeping staff X on 6/5/13 at approximately 12:35 P.M. staff stated the facility extracted the carpet about twice a week, the facility used bleach to try to return the carpet to its natural color, (causing the lighter areas), staff was not sure the causes of the spots, therefore the facility did not know which type of cleaning agent to attempt. Housekeeping staff X stated the facility had not replaced the carpet due to other expenses. The facility failed to ensure a clean and comfortable environment.	{F 253}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	{F 279}		4/26/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 3 This Requirement is not met as evidenced by: The facility identified a census of 46 residents. The sample included 8 residents. Based on observation, record review and interview the facility failed to develop a comprehensive and individualized care plan for 2 of 3 (#27, #23) residents reviewed. Findings included: - The Annual Minimum Data Set 3.0 (MDS) for resident #27 dated 3/28/13 revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The resident required total dependence on 2 or more people for toilet use and bathing, was not steady, only able to stabilize with human assistance, and had a prognosis of 6 months or less. The 3/31/13 Care Area Assessment (CAA) for psychosocial well-being revealed staff needed to provide things of enjoyment for the resident when he/she had the energy to do those things. The care plan regarding activities of daily living (ADLs) and hospice with a revision date of 4/15/13 revealed the resident was placed on hospice services on 3/16/13, and to refer to the hospice care plan provided by the hospice group, and to contact the hospice group for care needs. The care plan then listed contact information for the hospice group. It also stated hospice would provide a specialty mattress, broda chair, gloves, medications except for Zetia (medication for high cholesterol), cranberry capsules, melatonin (helps to regulate sleep), and multivitamin for the resident. The care plan lacked documentation of what disciplines such as nursing, home health aid, social work, chaplain, that the resident would	{F 279}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 4 receive. It also lacked information regarding frequency of visits from the hospice group and what care services they would provide. Observation on 6/4/13 at 12:47 P.M. revealed the resident sat in a chair in the television room with his/her walker within reach, watching television. Interview on 6/4/13 at 3:50 P.M. with licensed nursing staff H revealed he/she would expect the facility's hospice care plan to show the frequency that hospice services would visit the resident and what they would provide. Interview on 6/5/13 at 10:30 A.M. with licensed nursing staff I revealed he/she would expect the care plan to include the frequency of hospice visits and what services were provided. Interview on 6/5/13 at 10:53 A.M. with administrative nursing staff D revealed he/she would expect the care plan to include what supplies the hospice group would provide for the resident and would not include what services or frequency of visits. Interview on 6/5/13 at 12:39 P.M. with administrative nursing staff E revealed he/she expected the care plan to list whatever services were provided by hospice. The Care Plan Process policy dated 3/2006, provided by the facility, revealed the care plan should identify discipline specific services and frequency. The facility failed to develop and individualized and comprehensive care plan regarding hospice services for this cognitively impaired resident. - Resident #23's quarterly Minimum Data Set	{F 279}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 5 (MDS) 3.0 dated 5/18/13 identified the resident scored 14 (cognition intact) on the Brief Interview for Mental Status, did not exhibit behaviors, was independent with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, and toilet use, and required limited staff assistance with dressing, eating, and personal hygiene. The resident's care plan dated 3/7/13 and revised on 4/16/13 included the resident needed staff reminders at times related to personal hygiene, the resident preferred staff to shave him/her, if the resident shaved himself/herself, staff set up the supplies, and provided supervision as needed with the steps of shaving. On 6/4/13 at 9:26 A.M. the resident laid fully dressed on top of the bed spread in his/her room. Observation revealed the resident had several days of facial hair. During interview with the resident at that time, he/she stated staff shaved him/her. On 6/4/13 at approximately 2:30 P.M. the resident sat in a chair in front of the visitor's bathroom. Observation revealed the resident had several days of facial hair. The resident stated he/she was waiting for staff to shave him/her. The resident stated it had been 4 days since staff had shaved him/her, and he/she would like staff to shave him/her every other day. On 6/4/13 at 3:22 P.M. the resident continued to sit in a chair in front of the visitor's bathroom. Observation revealed the resident with several days of facial hair and several residents in line by the personal care room. On 6/4/13 at 3:43 P.M. the resident sat in the	{F 279}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 6 beauty shop chair in the personal care room and direct care staff O shaved the resident. During interview with direct care O on 6/4/13 at 4:04 P.M. staff stated if the evening shift had 3 certified nurse aides, staff opened up the personal care room and shaved residents per resident's request. Direct care O stated the resident's shaving did not coincide with any particularly schedule or shower day, and the resident required staff assistance with shaving. Licensed nurse H on 6/4/13 at approximately 4:35 P.M., stated the resident required staff assistance for shaving. Licensed nurse H stated the evening shift opened up the personal care room from 3:00 P.M. to 4:30 P.M. and shaved residents per resident's request. Licensed nurse H stated the resident received his/her showers on the evening shift once a week. On 6/5/13 at 9:34 A.M. direct care staff P stated the resident received his/her bath/showers on evening shift; therefore the evening shift shaved the resident. On 6/5/13 at 10:00 A.M. licensed nurse I stated unless the resident requested, the day shift did not shave the resident. On 6/5/13 at approximately 12:45 P.M. nursing administrative staff D stated the facility shaved residents per his/her choice and should be included in the resident's care plan. Review of the facility's Care Plan policy and procedure dated 3/2006 included the interdisciplinary team would coordinate with the resident and the legal representatives an appropriate care plan for the resident's needs or	{F 279}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 279}	Continued From page 7 wishes based on the assessment and reassessment process within the required time frames. The facility failed to develop an individualized shaving care plan for this resident based upon the resident's choice.	{F 279}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 46 residents. The sample included 8 residents. Based on observation, record review and interview the	{F 329}		4/26/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 8 facility failed to identify appropriate black box warnings (BBWs) for 1 (#30) of the 3 residents reviewed for medications and failed to monitor medication effectiveness for 2 (#24, #1) of the 3 residents reviewed for medications. Findings included: - The annual Minimum Data Set 3.0 (MDS) dated 3/1/13 for resident #24 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. He/she required supervision with eating, personal hygiene, and bathing and received antipsychotic, antidepressant, and diuretic medications during the seven day look back period. The Care Area Assessment (CAA) dated 3/8/13 for psychotropic medication use revealed the resident received multiple psychotropic medications and required monitoring for therapeutic effects and possible side effects. The care plan regarding BBWs with a revision date of 4/16/13 revealed staff monitored for potential adverse effects. The April 2013 behavior monitoring flow sheet revealed the resident received Risperdal (an antipsychotic medication) and Cymbalta (an antidepressant). Risperdal was listed as targeting the behavior of "intentional incontinency/refuses to wear undergarment." Risperdal and Cymbalta were listed as targeting the behavior of "angry responses." No medication was listed for targeting the behaviors of "intrusive/oversteps boundaries" or "episodes of poor safety awareness," but staff documented the resident was monitored for those behaviors.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 9 The May 2013 behavior monitoring flow sheet revealed the resident received Risperdal, Cymbalta, and Topamax (an anticonvulsant). Risperdal was listed as targeting the behavior of "intentional incontinency/refuses to wear undergarment." Risperdal, Topamax, and Cymbalta were listed as targeting the behavior of "angry responses." Risperdal and Topamax were listed as targeting the behavior of "intrusive/oversteps boundaries." Risperdal, Cymbalta, and Topamax were listed as targeting the behavior of "episodes of poor safety awareness." The May 2013 behavior monitoring flow sheet revealed the resident received Risperdal, Cymbalta, and Topamax. Risperdal was listed as targeting the behavior of "intentional incontinency/refuses to wear undergarment." Risperdal, Topamax, and Cymbalta were listed as targeting the behavior of "angry responses." Risperdal and Topamax were listed as targeting the behavior of "intrusive/oversteps boundaries." Cymbalta and Topamax were listed as targeting the behavior of "episodes of poor safety awareness." Observation on 6/4/13 at 12:53 P.M. revealed the resident was resting quietly in bed. Interview on 6/4/13 at 3:50 P.M. with licensed nursing staff H revealed the staff was unable to explain which behavior prompted the use of the medications listed on the behavior monitoring sheets. Interview on 6/5/13 at 10:21 A.M. with licensed nursing staff I revealed the staff was unable to explain which behavior prompted the use of the medications listed on the behavior monitoring	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 10 sheets. Interview on 6/5/13 at 10:53 A.M. with administrative nursing staff D revealed the staff was unable to explain which behavior prompted the use of the medications listed on the behavior monitoring sheets. The facility failed to monitor the effectiveness of medications for this resident. - The quarterly Minimum Data Set 3.0 (MDS) for resident #1 dated 4/20/13 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident displayed hallucinations, delusions, and inattention and disorganized thinking behaviors. The resident required 1 person limited assist for personal hygiene and received antipsychotic and antianxiety medications during the seven day look back period. The Care Area Assessment (CAA) for psychotropic medication use dated 8/1/12 revealed the resident received daily doses of psychotropic medications and was at risk for potential side effects. The care plan regarding falls and psychotropic medications with a revision date of 5/22/13 revealed staff monitored the resident for any signs and symptoms of side effects and report findings to the physician. The behavior monitoring flow sheet for April 2013 revealed the resident received Clozaril (an antipsychotic medication), Invega (an antipsychotic medication), Klonopin, (an antianxiety medication), Lithium (a mood stabilizer), and Haldol (an antipsychotic	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 11 medication). Clozaril and Haldol were listed as targeting the behavior of "responding to unseen others." Clozaril and Invega were listed as targeting the behavior of "disorganized thought and flight of ideas." Lithium was listed as targeting the behavior "poor self care." No targeted behavior was listed for the use of Klonopin. The behavior monitoring flow sheet for May 2013 revealed the resident received Clozaril, Invega, Klonopin, Lithium, and Haldol. Clozaril, Invega, and Haldol were listed as targeting the behavior of "responding to unseen others." Clozaril, Lithium, Haldol, and Invega were listed as targeting the behavior of "disorganized thought and flight of ideas." Lithium, Clozaril, and Invega were listed as targeting the behavior "poor self care." No targeted behavior was listed for the use of Klonopin. The behavior monitoring flow sheet for June 2013 revealed the resident received Clozaril, Invega, Klonopin, Lithium, and Haldol. Clozaril and Haldol were listed as targeting the behavior of "responding to unseen others." Clozaril and Invega were listed as targeting the behavior of "disorganized thought and flight of ideas." Lithium, Clozaril, and Invega were listed as targeting the behavior "poor self care." No targeted behavior was listed for the use of Klonopin. The behavior monitoring flow sheets for April 2013, May 2013, and June 2013 revealed multiple medications associated with a single behavior that staff monitored for the resident. Observation on 6/4/13 at 3:45 P.M. revealed the resident sat in a chair outside on the patio	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 12 smoking a cigarette. Interview on 6/4/13 at 3:50 P.M. with licensed nursing staff H revealed the staff was unable to explain which behavior prompted the use of the medications listed on the behavior monitoring sheets. Interview on 6/5/13 at 10:21 A.M. with licensed nursing staff I revealed the staff was unable to explain which behavior prompted the use of the medications listed on the behavior monitoring sheets. Interview on 6/5/13 at 10:53 A.M. with administrative nursing staff D revealed the staff was unable to explain which behavior prompted the use of the medications listed on the behavior monitoring sheets. The facility failed to monitor the effectiveness of medications for this resident with moderate cognitive impairment. - Review of resident #30's June Medication Administration Record (MAR) revealed on 5/29/13 the physician gave an order for the resident to receive 500 milligrams (mg) of Keflex (an antibiotic) two times a day and 800 mg of Ibuprofen (nonsteroidal anti-inflammatory agents-NSAIDs) three times a day as needed for pain. The MAR included Ibuprofen had a BBW (black box warning). The resident's quarterly Minimum Data Set (MDS) 3.0 dated 4/5/13 identified the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status, was independent with bed mobility, transfers, walking	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 13 in the room/corridor, locomotion on/off the unit, dressing, toilet use, and personal hygiene. The MDS recorded the resident had received an antipsychotic, and an antidepressant for 7 days of the 7 day assessment period. The resident's Psychotropic Care Area Assessment (CAA) dated 10/12/12 documented the resident received psychotropic medication and had no obvious adverse side effects. The resident's care plan dated 4/11/13 addressed the resident's medications including black box warnings and side effects. A handwritten entry dated 5/29/13 included the resident was started on Keflex (an antibiotic), and Ibuprofen. Review of resident's care plan and medical record lacked evidence of side effects (SE) for the Keflex and Ibuprofen and a black box warning for the Ibuprofen. Review of information from the Food and Drug Administration (FDA) revealed the BBW for Ibuprofen included: NSAIDs may cause an increased risk of cardiovascular thrombotic events, myocardial infarction, and stroke, which could be fatal, and the risk may increase with duration of use. On 6/4/13 at approximately 3:00 P.M. the resident sat in a chair. On 6/5/13 at 9:59 A.M. licensed nurse I stated the facility listed the BBW's in the resident's care plan and side effects were on the resident's care plan and MAR. Licensed nurse I stated when residents were started on a new medication, the pharmacy sent over the BBW and SE reports. Licensed nurse I confirmed the resident's care plan did not include the BBW for the Ibuprofen or	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 329}	Continued From page 14 the side effects for the Ibuprofen and Keflex. During interview with nursing administrative staff D on 6/5/13 at approximately 1:00 P.M., staff confirmed the BBW for the Ibuprofen was not on the resident's care plan and the side effects for the Keflex and Ibuprofen were not included in the resident's care plan or MAR. The facility policy and procedure for side effect information dated 6/26/08 included resident specific side effect information sheets including a listing of possible side effects for each medication prescribed would be provided for each resident, and the information sheet was kept in the MAR book. The facility's policy and procedure for BBW's dated 6/5/13 included resident-specific BBW's sheets was provided for each resident. The facility failed to monitor for the side effects of all medications the resident received.	{F 329}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	{F 441}		4/26/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 15 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 46 residents. Based upon observation, record review, and interviews the facility failed to follow the manufacture's recommendations regarding contact time when disinfecting a shared blood glucose monitor, and failed to follow acceptable standards of infection control when performing accu checks during 2 of 2 observations. Findings included: - On 6/4/13 at approximately 4:40 P.M. licensed nurse H placed a caddy with insulin supplies and 3 vials of insulin on top of a metal cabinet in the personal care room and applied clean gloves. Observation revealed licensed nurse H did not	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 16 disinfect or provide a clean field on the counter top prior to placing the items on the cabinet. At approximately 4:45 P.M. licensed nurse H assisted resident #48 to perform an accu-check. Licensed nurse H placed 2 alcohol wipes and the resident's blood glucose monitor case (single use device) on top of the cabinet. The resident wiped his/her finger with an alcohol wipe, placed the wipe on top of the cabinet, performed the accu-check and placed the monitoring strip (with blood) on top of the alcohol wipe located on the cabinet. Further observation revealed the top half of the strip on the alcohol wipe and the lower half (with the blood) touched the cabinet top. Licensed nurse H removed and applied new gloves. Observation did not reveal licensed nurse H performed hand hygiene. On 6/4/13 at approximately 4:50 P.M. resident #45 entered the personal care room. Resident #45 cleaned his/her finger with an alcohol wipe, and placed the alcohol wipe on the cabinet. Licensed nurse H assisted the resident to perform the accu-check, after performing the accu-check, licensed nurse placed the monitoring strip on top of the alcohol wipe. Licensed nurse H cleaned the top of the insulin vial with an alcohol wipe, placed the wipe on the cabinet, withdrew the insulin, picked up the used alcohol wipe (one used to clean the top of the insulin vial) and cleaned the resident's abdomen with the alcohol wipe prior to administering the insulin. Licensed nurse cleaned the blood glucose monitor with a germicidal wipe after performing the accu-check. Observation revealed licensed nurse H did not disinfect or ensure a clean field on the cabinet prior to assisting resident #45 with the accu-check. Observation revealed licensed nurse H did not disinfect the shared blood glucose monitoring device prior to performing	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 17 resident #45's accu-check. During interview with licensed nurse H he/she stated the blood glucose device used for resident #45 was a shared device and he/she had to wait a few minutes after cleaning the monitor before performing another accu-check. Licensed nurse H stated the blood glucose device was already cleaned; therefore he/she did not clean the device prior to performing the accu-check. Licensed nurse H removed and applied clean gloves but did not perform hand hygiene. On 6/4/13 at 4:57 P.M. resident #35 entered the personal care room. Licensed nurse H did not disinfect or provide a clean field prior to performing the accu-check. On 6/5/13 at 11:09 A.M. licensed nurse I entered resident #45's room to perform an accu-check. At 11:09 A.M. licensed nurse I disinfected the blood glucose monitor with a germicidal wipe, and at 11:10 A.M. licensed nurse I performed the accu-check. Review of the disinfecting instructions on the germicidal wipe container on 6/5/13 revealed a contact time of 2 minutes. On 6/5/13 at approximately 12:00 P.M. licensed nurse I stated after he/she cleaned the blood glucose meter, he/she waited 10-15 seconds prior to performing an accu-check. Licensed nurse I stated he/she was not aware of the contact time. Licensed nurse I read the disinfecting instructions on the germicidal container and stated the contact time was 2 minutes. During interview with administrative nursing staff D on 6/5/13 at approximately 12:30 P.M., staff	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	R 06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 18 stated resident's shared the blood glucose monitor, staff cleaned the meter prior to each use and followed the facility's blood glucose policy and procedure. Review of the facility's undated blood glucose monitoring policy and procedure included staff performed hand hygiene before the procedure, and applied clean gloves. The policy and procedure did not include how to disinfect the blood glucose monitor. The facility failed to disinfect the blood glucose monitor per manufacturer's instructions, failed to ensure staff performed hand hygiene prior to the procedure, failed to disinfect the cabinet between use and failed to ensure a clean field.	{F 441}		